DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/31/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	JETIPLE CO	ONSTRUCTION O1	COMP	LETED	
155479		A. BUII		01	01/10/2		
100473		B. WIN			0 17 1072	-012	
NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE				1010 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON CENTER RI WAYNE, IN46825	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
K0000	and State Licenconducted by the Department of accordance with Survey Date: Our Facility Number: Our Facility Numbe	th 42 CFR 483.70(a).  1/10/12  r: 000522 er: 155479 100267040  Kelley, Life Safety  ety Code survey, Center of Fort and not in th Requirements for  caid, 42 CFR 0(a), Life Safety the 2000 edition of re Protection EPA) 101, Life Safety with 410 IAC 16.2. Iding consisting of 100 halls was Chapter 19, Existing	K	0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XZBZ21

Facility ID:

000522

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155479		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 01/10/2012			
	PROVIDER OR SUPPLIER	OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE  1010 W WASHINGTON CENTER RD  FORT WAYNE, IN46825					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	construction ar sprinklered. The alarm system was detection in the open to the conresident rooms. Single station is smoke detector installed in all 100, 200 and 3 facility has a call had a census of this survey.  Quality Review by Code Specialist-Media The facility was compliance with aforementioned.	be of Type V (111) and was fully the facility has a fire with smoke the corridors, areas fridors and all to on 400 hall. to battery operated tres have been tresident rooms on the spacity of 120 and frido at the time of  Robert Booher, Life Safety dical Surveyor on 01/11/12.							
K0067 SS=E	•	ecifications. 19.5.2.1, 9.2, 2.2 evation and	K	0067	Kingston Care Center has requested and received a wa		01/23/2012		
FORM CMS-2	567(02-99) Previous Versio	·	XZBZ21	Facility I	for K067 annually by the Sta  D: 000522 If continuation s		ge 2 of 6		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155479		LDING	NSTRUCTION  01	(X3) DATE ( COMPL 01/10/2	ETED
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					WASHINGTON CENTER RD		
	NGSTON CARE CENTER OF FORT WAYNE			FORTV	VAYNE, IN46825		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
	ensure 4 of 6 egress corridors						
	were not being used as a portion						
	of a return air	system/plenum for					
	air conditionin	g, heating and					
	ventilating (HV	AC) duct work					
	serving adjoini	ng areas. NFPA					
	90A, the Stand						
		Air Conditioning					
	and Ventilation						
	2-3.11.1 requires egress corridors shall not be used as a portion of a						
	supply, return						
	I .	adjoining areas.					
		oractice could affect					
	71 of the 109 residents.						
	Findings includ	de:					
	Based on obse	rvations on					
	01/10/12 on a	tour of the facility					
	1	n. to 2:00 p.m. with					
	the Operations						
		and the support					
		00, 200 and 300					
	halls and the common center hall were using the egress corridors as a return air system. Based on an interview with the Operations Director at the time of						
	observation, the facility had modified the HVAC system so						
		e fire alarm system					
	shuts off suppl						
	эпасэ он заррі						

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AND PLAN OF CORRECTION   IDENTIFICATION NUMBER: 155479	(X5) IPLETION
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1010 W WASHINGTON CENTER RD	IPLETION
NAME OF PROVIDER OR SUPPLIER  1010 W WASHINGTON CENTER RD	IPLETION
	IPLETION
	IPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
	DATE
Additionally, duct work connected	
to the air supply fans are	
equipped with duct detectors	
located downstream of the air	
filters, which when activated, shut	
off supply air fans. Finally, the	
HVAC ducts did not penetrate any	
fire or smoke barrier walls,	
eliminating the need for the	
installation of smoke dampers to	
prevent the transfer of smoke	
from one smoke compartment to	
another.	
another.	
3.1-19(b)	
K0000	
A Life Safety Code Recertification K0000	
and State Licensure Survey was	
conducted by the Indiana State	
Department of Health in	
accordance with 42 CFR 483.70(a).	
accordance with 42 CFN 403.70(a).	
Survey Date: 01/10/12	
Facility Number: 000522	
Provider Number: 155479	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XZBZ21 Facility ID:

000522

If continuation sheet

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AND PLAN OF CORRECTION ID:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)	MULTIPLE CO			(X3) DATE SURVEY COMPLETED		
		155479		UILDING	02		01/10/2012		
		100773	B. W	/ING			01/10/2	V 1 Z	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STA	-			
KINGSTON CARE CENTER OF FORT WAYNE					WASHINGTON /AYNE, IN46825				
					/ATINE, IN40023	) 			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)			(X5)	
PREFIX TAG				PREFIX TAG			E COMPLETION DATE		
TAG	AIM Number: 100267040			TAG				DATE	
	AIM Number:	100267040							
		W II - 116 G C .							
	· ·	Kelley, Life Safety							
	Code Specialist								
		ety Code survey,							
	Kingston Care								
	Wayne was fou								
	compliance wit	h Requirements for							
	Participation in								
	Medicare/Medi	caid, 42 CFR							
	Subpart 483.70	O(a), Life Safety							
	from Fire and the 2000 edition of								
	the National Fir	re Protection							
	Association (NFPA) 101, Life Safety Code (LSC) and with 410 IAC 16.2.								
	The 2007 addit	tion of the 400 Hall							
	was surveved w	vith Chapter 18,							
	· -	re Occupancies.							
	This one story	facility was							
	-	be of Type V (111)							
	construction ar	* *							
		he facility has a fire							
	alarm system w								
		e corridors, areas							
	open to the cor	•							
	l -								
	resident rooms on 400 hall. Single station battery operated smoke detectors have been installed in all resident rooms on 100, 200 and 300 halls. The								
	racility has a ca	apacity of 120 and							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	XZBZ2	21 Facility I	D: 000522	If continuation sh	leet Pac	ge 5 of 6	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 02		X3) DATE S COMPL			
		155479		A. BUII B. WIN				01/10/2	
NAME OF B	ADOLUDED OD GLIDDLIED			B. WIIV		DDRESS, CITY, STA	ATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER						WASHINGTON			
		OF FORT WAYNE				VAYNE, IN4682	5		
(X4) ID		TATEMENT OF DEFICIEN			ID	PROVIDER'S P	LAN OF CORRECTION E ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED  LSC IDENTIFYING INFO			PREFIX TAG	CROSS-REFERENCE	ED TO THE APPROPRIAT ICIENCY)	E	COMPLETION DATE
1110		f 109 at the time			1110				5.112
	this survey.	. ros at the time							
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: X				XZBZ21	Facility I	D: <b>000522</b>	If continuation sh	eet Pag	ge 6 of 6